Rapid Desk Review: Cultural, Context and the Mental Health and Psychosocial Wellbeing of Internally Displaced Colombians and Venezuelan Migrants and Refugees living in Colombia

Colombia has suffered from decades of armed conflict between the guerrillas, paramilitary and government forces. Historically, the fight has been over power, natural resources and control of drug production. Civilians have been the most affected by this conflict. Displacement in Colombia is mostly the result of a long-standing armed conflict which originated in the 1960s, designated as a low-intensity asymmetric war. The Colombian conflict is complex, it is composed by various actors (left wing guerrilla, right wing paramilitary, the Colombian security forces) and it has continuously evolved during the last five decades (IDMC, 2012). A peace agreement signed between the largest guerrilla movement (FARC) and the Colombian government in 2016 has been said to have a positive effect on the number of persons being displaced. Despite the peace agreement, generalized violence in Colombia continues. Other guerrilla groups - such as the National Liberation Army (ELN) and the demobilised FARC - as well as large criminal gangs and violence from drug trafficking continues to cause displacement (Castaño-Pérez et al., 2018). During the last ten years, Colombia has repeatedly featured as the first or second country with the highest number of IDPs. In 2016, the Colombian government reported that 7.7 million Internally Displaced Persons in Colombia (United Nations High Commissioner for Refugees, 2017).

The number of IDPs reported by the Colombian government should be taken with caution as it is cumulative. Since the main objective of country's database (Registro Único de Victimas in Spanish also known as RUV) is to provide access to government services to the victims of the armed conflict, they do not account for the number of persons who are no longer displaced, in a stable condition or have died, which means that the number of IDPs reported by the government never decreases (IDMC, 2016). Similarly, some Colombian IDPs do not choose to register because of fear and the displacement that has taken place because of the post-demobilisation of the FARC is also not consider into this statistic (IDMC, 2012). As of April 2018, the RUV has reported 7,365 displaced persons and anecdotal evidence indicates that displacement continues to affect many Colombians. A study conducted in the outskirts of Bogota found that in a sample of 2,082 displaced persons, 81% had been displaced once and 17% had been forcibly displaced twice (Hernández-Bello & Gutiérrez-Bonilla, 2008).

Displacement in Colombia is characterised by a paradox, despite the large reported number of displaced persons, Colombian IDPs are not geographically visible (Shultz, García, et al., 2014). In contrast to other contexts (e.g. IDP camps in Borno state, Nigeria), IDPs do not live in camps or

designated areas. Most of the armed conflict related violence has taken place in rural areas and Colombian IDPs tend to move to marginal part of urban areas where they are often expose to violence (e.g. threats, abductions, forced requirement, intimidation) and poor living conditions which may lead to further displacement within cities (IDMC, 2016). In 2012, the coastal departments of Antioquia, Nariño, Cauca, Valle del Cauca and Córdoba produced the highest numbers of IDPs (IDMC, 2012). Most IDPs currently reside in the large and medium-size cities of Colombia. The main drivers of displacement have been clashes between armed groups for control of areas, forced recruitment, threats and murders (Shultz, Ceballos, et al., 2014).

Colombia has a 2-tiered medical system, a privatized sector and the General System for Social Security in Health (Sistema General de Seguridad Social en Salud – SGSSS). The administration of this public health system is provided by the EPS (Empresas Promotoras de Salud) and the services from this system are provided by the IPS (Instituciones Prestadoras de Servicios). A person gains access to this system by contributing to the social security services or, if the person is unable to contribute, by receiving a subsidy from the Government. Since 1997, the government has launched an action plan to increase the access to health services among internally displaced persons. Despite these efforts, many barriers persist and geographic and administrative barriers still hinder IDPs access to health services. The barriers to accessing mental care for IDPs in Colombia include inability to pay for consultations, difficulties caused by bureaucratic requirements, discriminatory treatment and lack of transportation to and from health clinics (Mogollón-Pérez & Vázquez, 2008).

The IDP population is principally composed of adolescents and younger adults in the age range of 10–39 years old, and the proportions of women are greater than the corresponding proportions of men (Shultz, Ceballos, et al., 2014). There are proportionally fewer elderly IDPs and ethnic minority groups (such as Afro-Colombian people) make up 13% of Colombian IDPs (CNMH, 2013). At national level, 8% of the population has not gone to school, while this percentage among the displaced population is between 21.4% and 23%. Accordingly, IDPs do not tend to have the education and training necessary for accessing the employment sector of the cities the move to. Unemployment is much higher among this population (76%) in comparison to 12% at national level, rates of underemployment and employment in the informal sector are also higher among this population which in turns translate into economic instability among the displaced population in Colombia (Hernández-Bello & Gutiérrez-Bonilla, 2008). Food security is also a challenge for this population as many were previously cultivating and producing crops that now they must buy (Hernández-Bello & Gutiérrez-Bonilla, 2008). The Norwegian Refugee council estimated that 33% of IDPs are children and young adults, and the majority

are never able to return to school following their displacement [13]. This reduces their chances of entering a stable workforce and leaving the cycle of poverty.

Catholicism is the dominant religion among the victims of the armed conflict. This proportion is smaller among victims of the armed conflict (60.7%) than in among the rest of the Colombian population (80%), 24.1% of women and 19.7% of men identified themselves as being part of other Christian groups (Rettberg, 2008). A study on 677 adults exposed to the armed conflict on coping strategies found religion to be one of the most used use coping skills among this population together with "waiting for things to be fixed on their own" this population tends to use religion as a coping strategy more that the average Colombian person (Hewitt-Ramirez et al., 2016). A qualitative study among women affected by the armed conflict identified religion as a common avoidance strategy in this population (Arnoso-Martínez, Cárdenas-Castro, Beristain, & Alfonso, 2017). *Brujería* is practiced in some parts of Colombia and, as Catholicism, is also part of the explanatory models of mental illness.

A qualitative study conducted with hospital officials indicates that mental health and domestic violence as well as adolescent pregnancy are main problems among the displaced population (Hernández-Bello & Gutiérrez-Bonilla, 2008). Malnutrition and behavioural problems are also perceived by doctors as prevalent conditions among displaced girls and boys (Hernández-Bello & Gutiérrez-Bonilla, 2008). Pregnancy, drug addiction, domestic violence and mental health conductions (particularly suicide attempts) were perceived as prevalent issues among young displaced women and men. Among adult women, sexual abuse, early pregnancy, abuse and malnutrition were frequent cited by doctors while in adult men, doctors perceived malnutrition and child maltreatment, communicable diseases and suicide attempts as common issues (Hernández-Bello & Gutiérrez-Bonilla, 2008).

Displacement has been shown to impact family structures. Hernández-Bello and Gutiérrez-Bonilla (2008) found higher proportions of extended family members and not family members living in the homes of displaced families in comparison to non-displaced families living in the same area (Hernández-Bello & Gutiérrez-Bonilla, 2008). The number of family members living in a house tends to decrease after displacement, and a higher number of women identified themselves as heads of household among displaced populations (Hernández-Bello & Gutiérrez-Bonilla, 2008). Displacement results on a higher number of persons living without their parents in the households, a common practice in the rural areas from which displaced persons from.

A prevalence study found over-reporting of self-reported poor health among IDPs living in the outskirts of Bogota, this over-reported presented at earlier ages (40 years old) among IDPs in

comparison to settle populations living in the same area (60 years old). Differences on disability were larger but not significant among IDPs. Local physicians perceived higher rates of chronic illness such as hypertension or diabetes among IDPs. They also reported higher rates on communicable diseases and higher prevalence of mental illness and higher reporting of domestic violence.

Colombian IDPs have experienced loss and traumatic events that have resulted in a significantly higher prevalence and variability of PTSD diagnosis when compared to the rest of the country's population (Lagos-Gallego et al., 2017). Some of the problems among this population are psychopathological disorders or psychiatric illnesses: fear and affliction as consequences of losses, the consumption of psychoactive substances, and other forms of violence and criminal acts. In addition, alterations have been reported in sleep, eating disorders, mood disorders, among other symptomatic manifestations of uprooting, nostalgia for the loss of people and places, guilt or shame in front of family conflicts, anger when remembering the humiliations to which they were exposed (National Center of Historical Memory, 2013).

The acts of violence related to the armed conflict produce a severe effect on the community to which the victims belong, both in the social and political organization in which they are immersed, and in relationships with their loved ones and family members (World Organization Against Torture, 2004). The population affected by forced displacement is exposed to traumas that cause symptoms such as nightmares, decreased sexual desire, like the other symptoms mentioned (Haghebaert and Zaccarelli, 2006).

A multi-city investigation among persons displaced by the armed conflict found statistically and clinically significant differences between the displaced population and a general population group. No differences were found in the consumption of cigarettes, alcohol and psychoactive substances. (Pan American Health Organization and National Institute of Health, 2002). Overall, and with respect to the prevalence of mental disorders in a population victim of forced displacement in Colombia, anxiety, depression, the use of substances and post-traumatic stress have been identified as the most prevalent conditions (Bernal, 2009; Pan American Health Organization and Regional Office for the Americas of the World Health Organization, 2002), in addition to the presence of family conflicts and aggressive behaviours.

Of the four million that have fled the country since the end of 2015, 1.3 million Venezuelans are now living in neighbouring Colombia, which currently hosts the largest number of Venezuelan refugees and migrants (United Nations High Commissioner for Refugees, 2019c). In addition to those residing in Colombia, many Venezuelans also cross to Colombia daily in order to eat at communal kitchens or buy food and medicines, before returning to Venezuela. Others stay in Colombia temporarily before transiting to other countries in the region (e.g., Ecuador, Peru, Brazil). Among refugees and migrants from Venezuela are also Colombians, many of who fled to Venezuela as a result of the Colombian internal armed conflict, and who are now returning to Colombia following the recent peace agreement and as a result of the humanitarian situation in Venezuela (Page et al., 2019).

Various interconnected factors are forcing Venezuelans to leave. The current complex humanitarian crisis in the country started in 2008, and is marked by hyperinflation, a widespread shortages of food staples, medicines and medical equipment, increased insecurity, violence and reports of human rights abuses, and the continuous deterioration of the national health and social welfare systems (Daniels, 2019).

Hyperinflation, which is estimated to reach 10 million percent by the end of 2019, as well as the collapse of the food infrastructure, puts the costs of food out of reach for nine in ten Venezuelans (The Lancet, 2019). In 2018, 82% of Venezuelans or 28.5 million people and 75% of health centres around the country did not have access to potable water (Daniels, 2019). Blackouts were also continuously reported, including a five-day widespread blackout in March 2019 (Daniels, 2019). Results from the National Hospital Survey 2019 suggest that 1,557 died in 2019 because of insufficient hospital supplies, although counts are likely underreported (Daniels, 2019).

According to local non-governmental organisations, the depleting health system has also led to an increase in morbidity and mortality due to infectious and parasitic diseases (e.g., malaria, measles, diphtheria), many of which had been previously controlled or eradicated (García, Correa, & Rousset, 2019). This increase in communicable diseases has been associated with inadequate access to basic sanitation, malnutrition and lack of vaccination campaigns (García et al., 2019). The deterioration of the Venezuelan health system has also severely impacted on infant mortality rates (21.1 deaths per 1000 livebirths), which in 2016 was almost 40% higher than in 2008 (García et al., 2019). Another report noted that by September 2019, 53% of operating theatres in Venezuela were closed, 71% of emergency rooms could not provide regular services and 79% of hospitals lacked a reliable water supply (Centre for Justice and Peace, 2018). According to Venezuela's leading pharmaceutical group,

85% of psychiatric medicines were unavailable and thousands of mental health patients had interrupted therapy because of a lack of medications in 2016 (Casey, 2016). Mental health institutions released patients due to food and medicine shortages (Casey, 2016). In 2013, and according to a report from the Ministry of Health, there were 23,630 long-term psychiatric patients in public hospitals, compared to only 5,558 in 2015 (Casey, 2016).

A recent report by the United Nations High Commissioner for Human Rights (2019) documents clear and serious violations to the highest attainable standard of health and food in Venezuela. This situation is further exacerbated by systematic reports of human rights abuses committed by state authorities, including excessive use of force against protestors, use of excessive force in non-protest related security operations, arbitrary detentions, torture and restrictions on democratic space (United Nations High Commissioner for Human Rights, 2018, 2019). Consequently, international protection considerations, according to the refugee criteria in the 1951 Convention/1967 Protocol and the 1984 Cartagena Declaration on Refugees are applicable to most Venezuelans (United Nations High Commissioner for Refugees, 2019b). Taken together, the most common reasons for leaving Venezuela among refugees and migrants include: violence, insecurity, fear of being targeted for their political opinions (whether real or perceived), shortages of food and medicine, lack of access to social services, and being unable to support themselves and their families (United Nations High Commissioner for Refugees, 2019b).

While some enter Colombia by air, many are traveling on foot. Known as “caminantes” or “walkers”, most lack financial means to travel to Colombia through any other means (International Rescue Committee, 2018). According to a needs assessment survey conducted by the International Rescue Committee in various cities across Colombia in September 2017, risks faced by refugees and migrants in transit included theft, extortion, physical violence and accidents (International Rescue Committee, 2018). Similarly, Venezuelan migrants and refugees in transit to Colombia have reported adverse travel conditions such as lack of shelter and food, and health conditions such as pneumonia and skin infections (International Rescue Committee, 2018). Moreover, Venezuelan refugees and migrants without the required documentation to enter Colombia legally are increasingly relying on irregular and dangerous routes to cross borders (known as “trochas”), which increases their risks of being sexually exploited, abused and kidnaped, especially in areas where illegal armed groups and guerrillas are still in operation (United Nations High Commissioner for Refugees, 2019b).

The Government of Colombia has put in place two special permits for Venezuelan refugees and migrants. In 2017, it introduced a Special Stay Permit ('Permiso Especial de Permanecia' or PEP, in its Spanish acronym) which allows Venezuelans who enter through formal border points to gain access to public services and request work permits (Response for Venezuelans, 2019). In addition, the government put in place a registration process for Venezuelan refugees and migrants who entered illegally, which allows them to later apply to receive the PEP (Response for Venezuelans, 2019). The government has also intermittently offered Border Mobility Cards which allow Venezuelans to enter Colombia frequently, for up to seven days (Response for Venezuelans, 2019). More recently, the Colombian government instated a temporary two-year measure to combat statelessness, whereby children born to Venezuelan parents in Colombia can receive Colombian citizenship, a legal exception that is supposed to immediately benefit around 24,000 children and which has received international praise and support (United Nations High Commissioner for Refugees, 2019a). These legal efforts have been accompanied by a series of expansions of basic rights and provision of basic services to Venezuelans, such as emergency healthcare and basic schooling in 2018 (Response for Venezuelans, 2019).

Though these are largely commendable initiatives, the resulting influx of forcibly displaced Venezuelans into Colombia has put considerable strain on the health care system, which is struggling to respond to the increased demand for health services (Daniels, 2019). In 2015, there were 1,475 emergency health-care treatments given to Venezuelans. In 2019, this number reached 131,958 (Daniels, 2019). As a result, various organizations including the UNHCR, International Organization for Migration (IOM), other UN agencies, NGOs and the Red Cross and Red Crescent Movement and other International Non-Governmental Organizations (INGOs), have stepped up operations to support the State's response to the growing needs of refugees and migrants from Venezuela, Colombian returnees and host communities (Response for Venezuelans, 2019).

A recent survey of service providers from UN organizations, INGOs, local NGOs, church-affiliated organizations and Venezuelan networks identified undocumented refugees and migrants as a highly vulnerable group, given their lack of access to ongoing government health, employment, housing, and education services (International Rescue Committee, 2018). Reported security threats to Venezuelans include violence, sex work, theft, extortion, xenophobia, sleeping on the street, working dangerous jobs, and risk of recruitment into armed groups or into the drug trade (International Rescue Committee, 2018), with undocumented refugees and migrants more likely to take on hazardous jobs with difficult conditions and circumstances. A survey administered to newly registered Venezuelans

showed that 46.3% of interviewees worked informally (Bahar, Dooley, & Huang, 2018). In addition, Venezuelan migrants and refugees are settling in different areas of Colombia, including areas affected by the Colombian armed conflict. This group is especially vulnerable as their settlement poses additional protection risks such as forced recruitment, secondary displacement, violence, human trafficking, abuse and Sexual and Gender-Based Violence (SGBV), and utilization in the narcotic production chain (Response for Venezuelans, 2019).

Women report additional threats compared to men, including sexual violence, sexual exploitation and slavery, transactional sex, sexual abuse, intimate partner violence, emotional and verbal abuse (e.g. receiving threats of being deported by their partners) as well as forced and early marriages (i.e. Venezuelans marrying Colombians to access documentation) (International Rescue Committee, 2018). Pregnant women as well as adolescent girls are identified as a particularly vulnerable group. The local public hospital in Cucuta, the Colombian border town through which most Venezuelan migrants and refugees enter Colombia, attended to 488 Venezuelan mothers in April 2019 alone, or 86% of the mothers treated that month (Daniels, 2019). A third of patients treated at the hospital are women, with pregnant women making up 20% of total patients treated (Daniels, 2019). No reports or studies have rigorously assessed the mental health needs of Venezuelan migrants in Colombia, resulting in information to date being largely anecdotal. Lastly, though no figures or needs assessments are currently available, a number of INGOs report incidences of Colombian returnees in need of international protection (Response for Venezuelans, 2019). Specifically, this subpopulation is in need of support to prevent re-victimization and to access institutional attention routes for victims of the armed conflict, with the aim of ensuring humanitarian assistance, compensation, and/or reparations for victims of human rights violations (Response for Venezuelans, 2019).

References:

Arnoso-Martínez, M., Cárdenas-Castro, M., Beristain, C. M., & Alfonso, C. (2017). Armed Conflict, Psychosocial Impact and Reparation in Colombia: Women's Voice. *Universitas Psychologica, 16*(3). doi:http://dx.doi.org/10.11144/Javeriana.upsy16-3.acpi

Bahar, D., Dooley, M., & Huang, C. (2018). *Integrating Venezuelans into the Colombian labour market: Mitigating costs and maximizing benefits*. Retrieved from https://www.brookings.edu/research/integrating-venezuelans-into-the-colombian-labor-market/

Casey, N. (2016). At a Loss for Meds, Venezuela's Mentally Ill Spiral Downward. *The New York Times*. Retrieved from https://www.nytimes.com/2016/10/02/world/americas/venezuela-mental-health-medicine-shortages.html

Castaño-Pérez, G. A., Sierra-Hincapié, G. M., Sánchez-Acosta, D., Semenova-Moratto, N., Salas-Zapata, C., Buitrago-Salazar, C., & Agudelo-Martínez, M. A. (2018). *Salud mental en víctimas de desplazamiento forzado por la violencia en Colombia. El caso de Bogotá, Medellín y Buenaventura*. Medellín: Editorial CES.

Centre for Justice and Peace. (2018). *Complex Humanitarian Emergency in Venezuela: Right to Health*. Retrieved from https://cepaz.org/documentos_informes/complex-humanitarian-emergency-in-venezuela/

CNMH. (2013). *Una nación desplazada: Informe Nacional de Desplazamieto Forzado en Colombia*. Retrieved from Bogotá: http://www.centrodememoriahistorica.gov.co/descargas/informes2015/nacion-desplazada/una-nacion-desplazada.pdf

Daniels, J. P. (2019). Colombia struggles to cope with care in Venezuelan influx. *The Lancet, 393*(10187), 2185-2186. doi:10.1016/S0140-6736(19)31229-2

García, J., Correa, G., & Rousset, B. (2019). Trends in infant mortality in Venezuela between 1985 and 2016: a systematic analysis of demographic data. *The Lancet Global Health, 7*(3), e331-e336. doi:10.1016/S2214-109X(18)30479-0

Hernández-Bello, A., & Gutiérrez-Bonilla, M. L. (2008). Vulnerability and Exclusion: Life Conditions, Health Situation, and Access to Health Services of the Population Displaced by Violence settled in Bogotá - Colombia, 2005. *Revista de Gerencia y Politicas de Salud, 7*(14), 145-176.

Hewitt-Ramirez, N., Juárez, F., Parada-Baños, A. J., Guerrero-Luzardo, J., Romero-Chávez, Y. M., Salgado-Castilla, A. M., & Vargas-Amaya, M. V. (2016). Afectaciones Psicológicas, Estrategias de Afrontamiento y Niveles de Resiliencia de Adultos Expuestos al Conflicto Armado en Colombia. *Revista Colombiana de Psiquiatría, 25*(1), 125-140. doi:10.15446/rcp.v25n1.49966

IDMC. (2012). *Global Report on Internal Displacement*. Retrieved from Geneva: http://www.internal-displacement.org/assets/publications/2016/2016-global-report-internal-displacement-IDMC.pdf

IDMC. (2016). *Global Report on Internal Displacement*. Retrieved from Geneva: http://www.internal-displacement.org/assets/publications/2016/2016-global-report-internal-displacement-IDMC.pdf

International Rescue Committee. (2018). *Venezuelan Migrants in Colombia: Expansion*. Retrieved from https://reliefweb.int/sites/reliefweb.int/files/resources/IRC%20Assessment-%20Venezuelans%20in%20Colombia%20Nov2018.pdf

Page, K. R., Doocy, S., Reyna Ganteaume, F., Castro, J. S., Spiegel, P., & Beyrer, C. (2019). Venezuela's public health crisis: a regional emergency. *The Lancet, 393*(10177), 1254-1260. doi:https://doi.org/10.1016/S0140-6736(19)30344-7

Response for Venezuelans. (2019). *Regional Refugee and Migration Response Plan* Retrieved from Geneva: https://reliefweb.int/report/colombia/regional-refugee-and-migrant-response-plan-refugees-and-migrants-venezuela-january

Rettberg, A. (2008). *Reparación en Colombia ¿Qué quieren las víctimas?* Retrieved from Bogota: http://www.bivipas.unal.edu.co/handle/10720/353

Shultz, J. M., Ceballos, Á. M. G., Espinel, Z., Oliveros, S. R., Fonseca, M. F., & Florez, L. J. H. (2014). Internal displacement in Colombia: Fifteen distinguishing features. *Disaster Health, 2*(1), 13-24. doi:10.4161/dish.27885

Shultz, J. M., García, N. M., Ceballos, Á. M. G., Florez, L. J. H., Araya, R., Verdeli, H., . . . the, O. O. T. (2014). Outreach to internally displaced persons in Bogotá, Colombia: challenges and potential solutions. *Disaster Health, 2*(2), 75-81. doi:10.4161/21665044.2014.954500

The Lancet. (2019). Venezuelans' right to health crumbles amid political crisis. *The Lancet, 393*(10177), 1177. doi:10.1016/S0140-6736(19)30729-9

United Nations High Commissioner for Human Rights. (2018). *Human Rights Violations in the Bolivarian Republic of Venezuela: a downward spiral with no end in sight*. Retrieved from https://www.ohchr.org/Documents/Countries/VE/VenezuelaReport2018_EN.pdf

United Nations High Commissioner for Human Rights. (2019). *Human rights in the Bolivarian Republic of Venezuela*. Retrieved from Geneva: https://reliefweb.int/report/venezuela-bolivarian-republic/report-united-nations-high-commissioner-human-rights-situation

United Nations High Commissioner for Refugees. (2017). *Global Trends: Forced Displacement in 2016*. Retrieved from Geneva: http://www.unhcr.org/5943e8a34.pdf

United Nations High Commissioner for Refugees. (2019a). Colombia acts to ensure children born to Venezuelan parents are not left stateless.

United Nations High Commissioner for Refugees. (2019b). *Global Trends: Forced Displacement in 2018*. Retrieved from Geneva: https://www.unhcr.org/5b27be547.pdf

United Nations High Commissioner for Refugees. (2019c). Refugees and migrants from Venezuela top 4 million: UNHCR and IOM. Retrieved from https://www.unhcr.org/news/press/2019/6/5cfa2a4a4/refugees-migrants-venezuela-top-4-million-unhcr-iom.html#